DUAL DEMONSTRATION CMS CORE MEASURES
AND DRAFT OPTIONAL MEASURES

Measure	Description	Data Source
1. Antidepressant Medication Management	Percentage of members diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment	NCQA/HEDIS
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA/HEDIS
4. Screening for Clinical Depression and Follow-up Care	Percentage of patients screened for clinical depression using a standardized tool and follow-up plan documented.	CMS
5. SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/HEDIS

6. SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/HEDIS
7. Care Transition Record Transmitted to Health Care Professional	Percentage of patients discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	NCQA/HEDIS
8. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS
9. SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/HEDIS
10. CAHPS, various settings	-Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	AHRQ/CAHPS
11. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Call Center data

12. Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS Call Center data
13. Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE
14. Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100	IRE
15. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)
16. Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data
17. Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data
18. Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2014.	CMS Medicare Beneficiary Database Suite of Systems

19. Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan
20. Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data
21. Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data
22. Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
23. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
24. Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
25. Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage	IRE
26. Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member’s appeal.	IRE

27. Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS Call Center data
28. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed
29. Consumer Governance Board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure
30. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS
31. Assessments	Percent of members with initial assessments completed within required timeframes.	CMS/State defined process measure
32. Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure
33. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure
34. Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure
35. Discharge Follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	CMS/State defined process measure
36. Self-direction	Percent of care coordinators that have undergone training for supporting self-direction under the Demonstration.	CMS/State defined process measure
37. Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS

38. Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a—functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS
39. Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS
40. Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS
41. Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS
42. Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS
43. Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS
44. Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS
45. Plan All-Cause Readmissions	Percent of members discharged from a hospital who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS
46. Controlling Blood Pressure	Percentage of members aged 85 and under who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS
47. Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA)
48. Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract	CMS CTM data

	enrollment)] * 1,000 * 30 / (Number of Days in Period).	
49. Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database
50. Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2015.	CMS
51. Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS
52. Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS

53. Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS
54. Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS
55. Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS
56. Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS
57. Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan. • Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS
58. Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS
59. Colorectal Cancer Screening Cardiovascular Care – Cholesterol Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer. Percent of plan members with heart disease who have had a test for ―bad (LDL) cholesterol within the past year.	NCQA/HEDIS
60. Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for ―bad (LDL) cholesterol within the past year.	NCQA/HEDIS

61. Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for ―bad (LDL) cholesterol within the past year.	NCQA/HEDIS
62. Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data
63. Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS
64. Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS
65. Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS
66. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS
67. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS
68. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS
69. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS
70. Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS

DUAL DEMONSTRATION CMS CORE MEASURES
AND DRAFT OPTIONAL MEASURES

Draft State Long Term Care Optional Measures (meet 1915c waiver requirements)

Performance Measure	MCO Requirement	Expected Performance Level
All new enrollees who have a level of care indicating a need for institutional/waiver services.	MCO will submit quarterly and annually a report on the number of new EDCD waiver enrollees	100%
The LOC of enrolled participants are reevaluated at least annually or as specified in the approved EDCD waiver.	MCOs will submit monthly to DMAS the number of EDCD waiver individuals who were due and received LOC re-evaluations within 365 of their initial LOC evaluation.	100%
The UAI was appropriately utilized to determine individual's level of care.	MCO's will assure all individuals will have a UAI screening to determine eligibility to EDCD waiver before providing long term care services. Submit a monthly report of the number of new enrollees.	100%
EDCD Waiver Services Plan of Care addresses all assessed needs and personal goals, either by EDCD waiver services or through other means.	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Wavier Services Plan of Care is developed in accordance with DMAS policies and procedures	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Waiver Services Plan of Cares are updated/revised at least annually or when warranted by changes in the waiver individual's needs	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD Wavier Services are delivered in accordance with the Plan of Care, including in the type, scope, amount, duration, and frequency specified in the Plan of Care	MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%

Individuals who meet criteria for long term services and supports are afforded choice: 1) Between waiver services and institutional care; 2) between/among waivers services and providers	MCO will have available the documentation for DMAS to conduct QMR review	100%
Licensed and non-licensed EDCD waiver service Providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services. *The only none EDCD licensed services are: PERS, Service Facilitation, and Transition Coordination.*	MCOs will document through their internal Quality Program that all of their providers meet or exceed the following credentialing standards. 1. Are DMAS enrolled providers. 2. Criminal record checks were run on all MCO & LTC provider employees and consumer directed providers. The MCO must separate their credentialing by Licensed and Unlicensed and provide a count in each category. MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
EDCD waiver services provider training is conducted in accordance with waiver and state requirements.	MCOs will document through their internal Quality Program that all Providers meet or exceed the MCO's training standards. In the following areas: Agency & Consumer Directed providers receive training 12 hours annually in accordance with training requirements outlined in the DMAS EDCD Wavier Manual. MCO will have available the documentation for DMAS to conduct QMR review	Must be >95%
The MCO, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	MCOs will document through their internal Quality Program that any allegation of Abuse Neglect or Exploitation is reported to the appropriate DSS. MCO will review the allegation and take necessary action to assure the health and safety of the individual. MCO will have available the documentation for DMAS to conduct QMR review	100%